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ABSTRACT

This doctoral research seeks to demonstrate the clinical utility of early memories by reviewing the current literature and providing a rationale for extending this research into the spiritual arena by highlighting the lack of available projective spiritual measures. Specific areas covered include an overview of early memory theory, technique and rating systems, as well as information pertaining to the ability of early memories to distinguish between types and levels of pathology, to be used as a measure of therapeutic change, to provide developmental information, and to assess health and normal personality variation. Research demonstrating the development of new projective probes is discussed. Information about the questionable reliability and validity of objective, self-report measures is presented, and the rising interest in spiritual issues is noted, both of which are used as a rationale for the development of the Early Spiritual Memory Test. Appendices include: "Comprehensive Early Memories Scoring System" and "Adelphii Early Memory Index (AEMI)." (Contains 59 references.) (Author/BT)

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REVIEW OF THE LITERATURE REGARDING EARLY MEMORIES AND THEIR EMERGING USE IN PROJECTIVE SPIRITUAL ASSESSMENT

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Joy M. Bustrum

May, 2003

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ABSTRACT

REVIEW OF THE LITERATURE REGARDING EARLY MEMORIES AND THEIR EMERGING USE IN PROJECTIVE SPIRITUAL ASSESSMENT

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Joy M. Bustrum

The purpose of this paper is to demonstrate the clinical utility of early memories by reviewing the current literature and to provide a rationale for extending this research into the spiritual arena by highlighting the lack of available projective spiritual measures. Specific areas covered include an overview of early memory theory, technique, and rating systems, as well as information pertaining to the ability of early memories to distinguish between types and levels of pathology, to be used as a measure of therapeutic change, to provide developmental information, and to assess health and normal personality variation. Research demonstrating the development of new projective probes is also discussed. Information about the questionable reliability and validity of objective, self-report measures is presented, and the rising interest in spiritual issues is noted, both of which are used as a rationale for the development of the Early Spiritual Memory Test.

REVIEW OF THE LITERATURE REGARDING EARLY MEMORIES

AND THEIR EMERGING USE IN PROJECTIVE

SPIRITUAL ASSESSMENT

by

Joy M. Bustrum

APPROVED:

Todd W. Hall, PhD — Date 4/9/03

Keith J. Edwards, PhD — Date 4/8/03

APPROVED:

Patricia L. Pike, PhD, Dean

4/9/03
Date

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One of my own early memories is that of a camping trip with my family in Africa. I remember how awe inspiring it was to watch a herd of elephants mingle through the Serengeti Plains, gracefully walking for miles in search of food and water. Elephants are by nature sensitive emotional and social creatures, gentle with their young and kind to their kin.

Like the matriarchs that lead the herd, Dr. Todd Hall and Dr. Keith Edwards have provided wisdom, guidance, and direction. Your presence throughout the years, and throughout this project in particular, has been significant, and I have learned much from my interactions with you.

Those who have mingled with me through the plains of Rosemead, the members of my own herd, are dear to my heart. Words cannot do justice to describe the impact you have had upon me during this season of life. Dad and Mom, Melanie and Jeff, Mark and Hannah, and Kevin: you have surrounded me with love and grace, enabling me to keep walking even when I complained of being weary. Your friendship and warm meals, Grandma, have brought me much joy, making my life rich. Grandpa and Grandma, your daily prayers and monthly letters have sustained me, calming my soul. And, Residents of 4860 and 213 (Coulter & Colima), your hearts are as big as the elephant's ears. You met me on the plains and walked with me through many long days and nights. My course has been altered because of it. To my herd – thank you.

REVIEW OF THE LITERATURE REGARDING EARLY MEMORIES AND THEIR EMERGING USE IN PROJECTIVE SPIRITUAL ASSESSMENT

Introduction

> Upon recalling one of his own earliest memories, Sigmund Freud wrote: [it] reminded me unmistakably of an accident of my own which I had brought on myself when I was between two and three years old. I had climbed up on a stool in the store-closet to get something nice that was lying on a cupboard or table. The stool had tipped over and its corner had struck me behind my lower jaw. I might easily, I reflected, have knocked out all my teeth (Anzieu, 1986, p. 242).

Freud analyzed some of his own early memories, giving credence to the fact that early memories have been clinically utilized for a number of years. Others would continue in his footsteps, developing the field of early memories, and noting, for example, the lack of a caregiver and the symbolism of mastery and ambition evident in Freud's early memory (Bruhn, 1995).

In recent years, there has been a surge of interest in utilizing early memories for clinical purposes. Early memories have been elicited, rated, and

interpreted in a variety of ways, generating rich clinical information. The heightened interest in early memories is perhaps due in part to the general doubts that have arisen around objective tests. Specifically, several studies have suggested that traditional self-report measures do not always assess what they purport to measure (Shedler, Mayman, & Manis, 1993; Tanaka-Matsumi & Kameoka, 1986).

Many researchers and clinicians are beginning to note the importance of attending to spiritual matters via the assessment process (Miller & Thoresen, 1999; Richards & Bergin, 1997); however, the field of spiritual assessment is dominated by objective self-report measures (Hill & Hood, 1999). In light of the fact that research has shown that early memories can reveal meaningful data, bypassing issues related to social desirability, it seemed natural and important to extend this means of assessment into the spiritual arena (Lin, Simopoulos, Murray, Edwards, & Hall, 2000; Lin, Bustrum, Edwards, & Hall, 2001). Eliciting early spiritual memories to assess spiritual health and maturity is a new field, and there is much yet to be researched and explored.

The purpose of this paper is to demonstrate the clinical utility of early memories. As such, the review is divided into two parts. The objective of part one is to provide an overview of early memories, including pertinent definitions, theories, techniques, and research. The literature review on early memories,

which concerns the bulk of this paper, is legion. In order to effectively organize the wealth of information, the following format will be utilized. First, articles will be reviewed by stating the research question and hypothetical presuppositions. Second, sampling procedures will be detailed. Next, relevant measures utilized in the study will be reviewed. Finally, significant results will be reported, and the strengths and weaknesses of the study will be assessed.

The objective of part two is to present a rationale for the emerging use of early memories in projective spiritual assessment. Part two will begin by discussing the discrepancies between objective and projective data, highlighting increasing doubts that have recently arisen around traditional self-report measures. Following this, the need for projective spiritual assessment will be addressed. The currently available projective measures will be investigated and critiqued, and the preliminary research on a new measure, the Early Spiritual Memory Test (ESMT), will be evaluated. Part two will finish with a synopsis of the literature. Concluding remarks will focus on the progress that has been made in researching early memories in general, and will explore possible directions for the future use of early memories in spiritual assessment.

Early Memories

An effective literature review requires a substantial comprehension of the constructs presented. It is at times confusing to wade through the current data without first gaining an appreciation for the people who have come before, including researchers, theorists, and clinicians, and the work that they have previously done. Therefore, this section will take care to present an operational definition of an early memory, to provide an overview of the major early memory theories, to examine early memory techniques, and to review the most pertinent early memory rating systems.

Definition

An early memory (EM) can be operationally defined as the recollection of a single, specific event, usually occurring at or before the age of 8. It is reported independently of other people, and the individual can usually visualize the event (Last, 1997; Watkins, 1992). The historical accuracy of the EM is unimportant; however, the individual must treat the memory as if it were a real occurrence.

Early Memory Theories

In order to provide a framework from which to understand the literature, it is important to review the development of early memory theory. The following provides an historical overview of this development by briefly highlighting the

most significant contributions of Sigmund Freud, Alfred Adler, ego psychology, cognitive-perceptual theory, and Martin Mayman.

Freudian. Early memory theory began circa 1899 with Sigmund Freud's concept of screen memories, which was closely connected to his belief in infantile amnesia (Bruhn & Last, 1982; Fowler, Hilsenroth, & Handler 1995; Fowler, Hilsenroth, & Handler 2000; Last, 1997). Freud proposed that most childhood memories and experiences are forgotten upon entering the latency developmental period, where the most significant task is to repress the Oedipal stage's incestuous and murderous fantasies directed toward parents and siblings. From an adaptive standpoint, repression is necessary in order for the child to have energy to continue further cognitive development. The remaining memories from the Oedipal stage are protectively distorted to keep the child from anxiety. Freud believed that these screen memories serve as a compromise of sorts between an unconscious forbidden wish and a defense against that wish, and used free association to discover the latent content of the memories (Bruhn & Last, 1982).

For Freud, early memories served to conceal, displace, or cover up other real, significant impressions. Because he believed that childhood amnesia resulted from the repression of infantile sexual impulses, Freud's goal as an analyst was to bring the repressed, infantile memories into awareness. Thus, Freud placed little importance upon the reported early memories themselves. In addition, Freud's

theory emphasized the determining role of early childhood experience upon personality functioning and its impact upon the whole course of development (Bruhn & Last, 1982).

Adlerian. Adler, a disciple of Freud, began his writings on early memories in 1912, disregarding the theory of infantile amnesia. In contrast to Freud, Adler focused on the manifest content of early memories. He maintained an emphasis on the present and suggested that early memories reveal fundamental aspects of an individual's current perception of him/herself and his/her life (Bruhn & Last, 1982; Chaplin & Orlofsky, 1991; Fowler et al., 1995; Last, 1997). As such, an individual selects memories from the past, real or imagined, which correspond to his or her attitude and worldview. From an Adlerian perspective, early memories serve as a means of self-justification, and are thus malleable, paralleling personality or life style changes (Bruhn & Last, 1982).

Ego Psychology. Ego psychological theory synthesized Freudian and Adlerian perspectives in the 1950s by retaining Freud's emphasis on the importance of early relationships and the process of repression in early memory formation, while still preserving Adler's present oriented focus (Bruhn & Last, 1982). An early memory was thus viewed as "an unconscious attempt by the individual to integrate, synthesize and resolve conflicts by reactivating experiences of childhood of similar emotional content" (p. 123). Ego psychologists maintain

that early memories are shaped by a variety of factors, including past life experiences, dreams, present levels of personality organization, current life stresses, and cultural milieu (Last, 1997). In addition, the manifest content of the early memory is not viewed simply as a screen. Rather, manifest content serves an adaptive function, and is a reflection of an individual's ability to manage the latent content.

Cognitive-Perceptual. As psychological theory began to embrace cognitive considerations, a cognitive-perceptual (CP) theory of personality, grounded in early autobiographical memories, was developed. Organized contextually, CP theory asserts that early memories tend to form around major unresolved issues (Bruhn, 1995; Last, 1997). The most negatively loaded affective memory contains clues as to where an individual is blocked in life, while positive affective memories provide information on how an individual can solve the problem. CP theory emphasizes, first, that an individual's current personality organization is mirrored in memories of the past, and second, that historical contributions to current problems can be identified by exploring memories of past events. In sum, not only does the present determine what one remembers from the past, but early memories are also a product of the creative processes within the self and have the ability to provide solutions to life's difficulties.

Mayman. Martin Mayman's approach to early memories is of particular importance to this review. Initially, while researching psychotherapy at the Menninger Foundation in the mid-1950s, Mayman conceptualized the reconstructive nature of early memories through Sir Fredrick Bartlett's experimental learning theory (Fowler et al., 2000). Bartlett believed that individuals remember selectively, accentuating some facts of the experience and ignoring others according to unique perceptional biases and personal dynamics. By 1960, Mayman (Mayman & Faris) was using early memories as a projective technique, stating that early memories contained inferences about one's self and others, incorporated transference paradigms, and were a source of information about the development of character.

Mayman's theoretical shift in 1967 blended ego psychology with object relations theory (Fowler et al., 2000). As noted above, ego psychology holds that early memories, containing unconscious relational experiences and expectations, influence identity formation. This theory was used as a framework from which to study the salient aspects of an individual's interpersonal matrix and, thus, infers the probable trajectory of ego-identity development. Object relations theory posits that early relationships are internalized and played out in other significant interactions during the course of life. Mayman assumed that the structure and content of early memories could delineate personality organization and could be

used to assess an individual's inner object world (Mayman, 1968; Fowler et al., 2000).

Like Adler, Mayman emphasized the revealing aspects of memories. Introducing the importance of narrative truth, Mayman also stressed that early memories are not necessarily autobiographical, and instead, "express psychological truths rather than objective truths about a person's life" (Mayman, 1968, p. 304). Mayman's ability to synthesize and integrate ego psychology and object relations theory led to a clinically astute projective assessment technique, aptly named the Early Memory Test (EMT).

Early Memory Techniques

Mayman first noted the clinical utility of gathering early memories in an article published in 1960. During the course of outpatient treatment, Mayman and a colleague, Mildred Faris (1960), obtained three sets of memories from a 24-year-old man and his mother and father. The patient was asked for his earliest and next earliest memory, his earliest and next earliest memory of his mother and father, the most striking early memory, and any other anecdotes that were told about him by his family. The patient's parents were asked to provide their most striking memory of the patient, an early memory, and the most characteristic memory. These memories were analyzed for style, structure, and thematic content. The inferences that Mayman and Faris made about the patient's personality

organization from his early memories were confirmed by other projective measures, and served as a "source of information regarding transference patterns carried into and re-enacted in each new personal encounter" (p. 520).

In 1968, Mayman developed the first systematic approach for gathering early memories when he queried for 16 specific memories of the self and of caregivers, and the Early Memory Test (EMT) was born (Fowler et al., 1995). The EMT begins by eliciting unstructured memories, and then focuses on circumscribed events, such as memories of anger, happiness, and fear. Additionally, the EMT also asks the patient for a description of the relationships in the memories, the patient's impression of self and others, and the overall mood or feeling of the memories (Karliner, Westrich, Shedler, & Mayman, 1996).

Using the cognitive-perceptual model as a theoretical framework, Bruhn introduced the Early Memory Procedure (EMP) in 1992 (Bruhn, 1992a). The EMP consists of two parts. In Part I, patients are asked to recall six spontaneous EMs, including their earliest memory. This is followed by scales to rate the predominant affect, instructions to rank order their most significant memories, requests for the rationale behind the rankings, and questions that help patients choose one memory and interpret it. In Part II, 15 directed memories, such as first school memory, first punishment memory, and most traumatic memory, are elicited. The EMP is analyzed via the précis technique, which identifies the

underlying pattern in the memory by reducing it to a statement of expectations – for example, "when x occurs, I expect y to follow" (Bruhn, 1992b; Bruhn, 1995).

Eliciting early memories as a projective procedure has several advantages. First, EMs may be less threatening than other projective techniques. Second, EMs provide a rich source of information about the patient's history and interpersonal dynamics while avoiding lengthy testing, scoring, and interpretative sessions. Third, some have suggested that EMs constitute a purer projective method in that they are not evoked by artificial stimuli (Tobey & Bruhn, 1992). Finally, EMs appear to be more stable than other projective methods because they are not significantly influenced by the experimental situation. However, despite their long-time appeal for psychodynamically oriented researchers and clinicians, EM techniques have been underutilized, perhaps in part due to the lack of a widely accepted scoring system (Last & Bruhn, 1983; Spirrison, Schneider, Harwell, Carmack, & D'Reaux, 1997; Watkins, 1992).

Early Memory Rating Systems

There have been several attempts to develop reliable rating systems for early memory techniques, and the three most prominently utilized in current research will be discussed. First, based on Adlerian theory, the Manaster-Perryman Manifest Content Early Recollections Manual (Manaster & Perryman, 1979) scores variables on a presence or absence basis. Scoring categories include

characters, setting, number and content of depicted themes, activity versus passivity, internal versus external locus of control, and affective tone. Research investigating interrater reliability for this scoring system has found a high percentage of rater agreement, ranging from 91% to 98%.

Second, the Comprehensive Early Memory Scoring System (CEMSS) and an elaboration, the Comprehensive Early Memory Scoring System-Revised (CEMSS-R), were developed by Jeffrey Last (Last & Bruhn, 1983; Last, 1997) and is based upon the cognitive-perceptual theory of early memories. Designed to be a comprehensive, general purpose system that assesses pathological and adaptive EM characteristics, the CEMSS categorizes EMs by nine content and process themes, including such variables as characters, setting, relation to reality, object relations, and affect (see Appendix A). Interrater reliability for the CEMSS has been assessed at 92.6% and at 94.5% for the CEMSS-R (Tobey & Bruhn, 1992).

Most recently, the Adelphi Early Memory Index (AEMI) was constructed by Karliner et al. (1996) in a series of five steps. First, in order to demonstrate that experienced clinical psychologists can be reliable judges, Karliner et al. recruited a panel of four clinical psychologists and had them evaluate 115 participants' mental health on a 5-point scale (-2 = distressed, -1 = probably distressed, 0 = unsure, +1 = probably healthy, +2 = healthy) using early memories obtained from

a short form of the EMT. The mental health ratings were averaged, and the alpha reliability for the composite rating was .79, indicating that the clinicians were able to reliably distinguish between levels of mental health.

In step two, Karliner et al. (1996) generated a pool of variables that could be used to score early memories, wrote the items that would be rated on a 5-point scale, and decided that raters should score the entire set of memories instead of basing their judgments upon a single memory. Eighteen variables were retained after rejecting items that did not have Spearman-Browne corrected reliabilities of .60 or above in step three, and a factor analysis yielded three factors (affect, narrative style, and presence/absence of trauma) in step four.

In step five, the AEMI variables were validated against clinical judgment. Although all three factors were significantly correlated with the composite clinical judgments of mental health, Factor I (Affect/Object Representation) correlated most highly, $r = .80$, $p < .001$ (Karliner et al., 1996). Because this factor accounted for the majority of the variance in a regression equation, the final version of the AEMI is composed of the nine variables related to affect and object relations that loaded on Factor I (see Appendix B). Karliner et al.'s scoring system is important in that it is an empirically derived, quantifiable rating scale that parallels clinical judgment.

The Use of Early Memories in Psychological Assessment

Throughout the years, considerable progress has been made in researching the clinical utility of early memories. A variety of studies have been conducted, addressing issues that range from alcoholism and the criminally dangerous to identity formation in adolescents and normal coping ability in adults. The most recent research will be reviewed in this section, and is organized by topic. Along with noting and appreciating the strides that have been made, such as using early memories to distinguish between levels of pathology or assessing how the concept of suicide is developed, the reader is encouraged to pay attention to the lack of a consistent technique to elicit early memories, the lack of uniform criteria for scoring early memories, and the lack of a standardized scoring system to rate early memories.

Alcoholism

Basing their research on the Adlerian theory of early memories, Chaplin and Orlofsky (1991) set out to investigate the validity of using early recollections as a projective device by comparing memories elicited from alcoholics and non-alcoholics with self-report measures of the same construct. Specifically, in terms of personality variables, the authors of this study hypothesized that early memories obtained from the alcoholic subject pool would contain more immature psychosocial themes, increased negative affect, more passivity, decreased social

interest, themes related to a negative self-concept, and an external locus of control when compared to the control group. Additionally, the researchers predicted that the early memories elicited from the alcoholic group post-treatment would show evidence of change in one or more of the variables mentioned above.

Chaplin and Orlofsky (1991) recruited 45 White male veterans from an inpatient, 4-week alcoholism treatment program at the Cleveland Veterans Administration Medical Center, and used 45 White male veterans drawn from local veteran service organizations as a control group. The two groups were similar in terms of ethnicity, gender, age, and military service. However, there was a significant difference in educational levels ($t(88)=2.31$, $p<.02$) and in marital status (27% of the alcoholics were currently married, compared to 91% of the control group). In order to compare early memories from the alcoholic group pre- and post-treatment, 10 of the original 45 alcoholic subjects and an additional 12 African American males participated in the second aspect of the study. These subjects were demographically similar to the other alcoholic subjects.

There were seven measures used in this study, four of which were self-report (Chaplin & Orlofsky, 1991). First, in order to screen for alcoholism, subjects were given the Short Michigan Alcoholism Screening Test (SMAST), a 13-item self-report scale of sound reliability and validity. The participants qualified for the control group if they received a score lower than two, which is the

suggested cut-off point. There was a significant difference between the control subjects (M=.3, SD= .5) and alcoholic subjects (M=10.0, SD=2.0), t (88)=31.73, p<.0001, on this measure.

Second, the Social Interest Scale (SIS), a 15-item forced choice inventory, was used to assess subject's interest in and concern for others. The third self-report measure consisted of the Rosenberg Self-Esteem Scale (RSE), and the fourth measure utilized was the Nowicki-Strickland Locus of Control Scale for Adults (ANSIE), a 40-item test scored in the external direction. Chaplin and Orlofsky (1991) report adequate reliability and validity for each self-report measure, and refer the reader to the original author's work for further discussion and examination (Crandall, 1981; Nowicki & Duke, 1974; Rosenberg, 1979; Selzer et al., 1975).

The Early Recollections Survey is a booklet that instructs subjects to write down three early memories. These memories were scored using two methods. First, the Manaster-Perryman Manifest Content Early Recollections Scoring Manual typically scores variables, such as the number and content of themes depicted (e.g., birth of a sibling, punishment), activity-passivity, internal-external locus of control, and affective tone, on a presence or absence basis. However, the authors (Chaplin & Orlofsky, 1991) in this study scored each variable across the three elicited memories, yielding continuous variables with four points (0, 1, 2, 3).

Social interest was measured by combining three Manaster-Perryman variables (givingness, mutuality, and lack of misdeeds) and thus yielded a single 10-point scale ranging from zero to nine. Chaplin and Orlofsky report that in numerous past studies interrater reliability for the Manaster-Perryman scoring categories has ranged from 91% to 98%.

The subject's early memories were also scored with Mayman's Scoring System, which classifies memories by psychosocial/psychosexual developmental levels: oral, involving themes of nurturance; anal, involving themes of rebelliousness or noncompliance; phallic, involving themes containing pleasure in mastery and strength; oedipal, involving themes of hostility or competition; and latency, involving themes of group acceptance or rejection. Chaplin and Orlofsky (1991) stated that satisfactory interrater reliability has been demonstrated using this scoring system in previous studies.

The results of the study generally supported the researcher's hypotheses (Chaplin & Orlofsky, 1991). First, a 2 X 3 repeated measures ANCOVA, covarying age of each memory, was used to compare alcoholic and control subject's scores on the immature psychosocial themes variable. The overall group effect was significant, $F(1, 87)=6.10$, $p<.02$, with alcoholic subjects obtaining lower psychosocial development scores than control subjects. Chi-square analyses were conducted to examine this difference further, and results indicated that the

difference between the two groups only reached significance for the memory offered first, $\chi^2(1, N=90)=6.67, p<.01$. In other words, although alcoholics were more likely to produce, for example, oral themes, than control subjects, this difference was only significant for the first of the three memories.

Second, the nature of the affective tone in the memories was assessed using the Manaster-Perryman affect variable, scored two for positive, one for neutral, and zero for negative manifestations (Chaplin & Orlofsky, 1991). The combined scores across the three memories created a 7-point scale ranging from 0 to 6. As expected, an ANOVA revealed a significant difference, $F(1, 88)=5.89, p<.02$, with alcoholic early recollections containing more negative tones than control subjects (M=1.9 and 2.8, respectively). Similarly, on the third hypothesis, another ANOVA revealed a significant difference, $F(1, 88)=5.08, p<.03$, consistent with the prediction that alcoholics would have more passive content in their memories than controls.

In terms of the fourth personality variable, social interest, an ANOVA was used to compare the groups and a significant difference was noted, $F(1,88)=7.43$, $p<.008$, with alcoholics' early recollections containing less evidence of social interest (Choplin & Orlofsky, 1991). Interestingly, although the two groups also differed somewhat in the same direction on the self-report measure (the SIS), and

although the early recollection index and the self-report scale were positively correlated, neither aspect was significant.

Because the subjects' level of education correlated positively with self-concept, an ANCOVA was utilized to assess this variable (Chaplin & Orlofsky, 1991). The group effect was significant, $F(1,87)=35.43$, $p<.001$, with the adjusted means lying in the predicted direction, reflecting the alcoholics lower self-concept. An ANCOVA with the Rosenberg Self-Esteem Scale also significantly differentiated between the groups in the same manner, $F(1, 87)=4.59$, $p<.04$. Additionally, RSE scores were significantly correlated with the early memory self-concept scores, $r(88)=.42$, $p<.001$.

Using an ANOVA, the results also supported the hypothesis that alcoholics' early recollections would reflect an external locus of control, $F(1, 88)=16.15$, $p<.001$. The self-report measure, the ANSIE scale, found similar results, $t(88)=1.89$, $p<.06$; however, the ANSIE scores were not significantly correlated with the early recollection locus of control index.

Finally, in terms of subjects' early recollections and therapeutic change, 22 subjects were re-administered the measures after approximately 18 days (Chaplin & Orlofsky, 1991). Correlated *t*-tests were used to compare the two sets of recollections. Although many variables showed positive changes, none of the early memory indexes or the self-report measures reached significance.

Chaplin and Orlofsky (1991) noted several weaknesses in their study such as limited generalizability due to the predominantly White male subject pool, a short length of time between pre- and post-test administrations, and issues relating to scoring that they imply led to low correlations between early recollections and self-report measures. However, this author suggests that the limited correlations between the early recollection indexes and the self-report measures do not call the indexes' validity into question. Instead, it is proposed that the early memories, like most projective data, are measuring different aspects of the constructs than self-report measures assess. In terms of strengths, this study utilized proper control groups, carefully assessed for interrater reliability of the early recollection ratings, and provided evidence that early recollections reveal certain aspects of the personality and can be used as a diagnostic tool.

Suicide

Early memory techniques have also been employed to examine the development of the concept of suicide. Clark (1992) asked subjects to recall their earliest suicide memory and their earliest suicidal thought in an effort to understand corresponding ages, means of exposure to suicide, motives for suicidal thought, emotional tones associated with the experience, level of disclosure to others, and methods contemplated.

Clark's (1992) subject pool consisted of 16 undergraduate students recruited from a southeastern university. There were 10 males (mean age=20.9) and 6 females (mean age=20.2). The subjects were asked four screening questions pertaining to suicide, and those who were able to provide an acceptable definition of suicide without endorsing any current suicidal ideation were admitted into the study. Individually interviewed by a doctoral-level psychology graduate student under direct supervision, the subjects were asked to relay their earliest recollection of suicide and their earliest recollection of wanting to kill themselves. The interviews were tape recorded, transcribed verbatim, and submitted to qualitative content analyses.

Most apropos to this paper are the results pertaining to emotional tones. Levy's (1965) scoring procedure for early memories was utilized to assess indexes related to: (a) active-passive ideation; (b) positive-negative emotional tone; (c) givingness, which refers to being given to, grabbing, or being abandoned; (d) mastery, which refers to self-assertion; and (e) mutuality, which refers to cooperation or competition. Results indicate that 40% of the female cases and 30% of the male cases contained a pervasively negative affective tone, while 60% of the female cases and 70% of the male cases conveyed a passive level of ego-participation. Additionally, 60% of the cases were related to the area of givingness, 26.7% to issues of mastery, and 13.3% to mutuality. A significant

gender difference was found in that only males' early memories of suicidal thoughts were directly related to issues of mastery.

Clark's (1992) study is significant in that it utilizes early memories to provide descriptive information about how the concept of suicide develops. The author was able to ascertain the average age of the earliest suicide memory (10.5 years), determine that the subject's earliest exposure to suicide was usually impersonal, verify the average age of the earliest suicidal thought (13.8 years), identify that motives for suicide were predominately in reaction to an external frame of reference (i.e., a significant break up), and categorize male and female methods of suicide (i.e., in terms of lethality). Further research in this area might focus, first, on using early memories to distinguish between levels of severity of suicidal ideation to aid in initial assessment, diagnosis, and prevention, and second, on attempting to qualitatively analyze specific aspects of the early memories to identify patients susceptible to or at risk for suicidal behavior.

The Criminally Dangerous

The efficacy of using early memories to distinguish between criminally dangerous and nondangerous psychiatric patients was demonstrated in a study by Tobey and Bruhn in 1992. The authors had two hypotheses. First, they suggested that dangerous psychiatric patients would differ from nondangerous patients by displaying more aggressiveness in the content of their early memories. Secondly,

Tobey and Bruhn used the study to test rating systems and proposed that the Early Memory Aggressiveness Potential Scoring System (EMAPPS) would more accurately distinguish between the two groups.

The sample for this experiment was appropriately selected; the dangerous group was composed of 30 male psychiatric patients from a maximum-security forensic hospital, while the nondangerous group consisted of 30 male psychiatric patients from a state psychiatric hospital (Tobey & Bruhn, 1992). The groups were similar in terms of age, socioeconomic status, intelligence, marital status, educational level, and diagnosis. However, there was a significant difference between the groups in ethnic composition. The dangerous group contained 17 African Americans patients and 13 White patients, while the nondangerous group was comprised of 6 African American patients and 24 White patients. Thus, the following includes the results of the statistical analyses performed to assess for this potential confound.

After administering the WAIS-R Vocabulary subtest, four early memories (EMs) were elicited from each subject, using Bruhn's (1989) procedure. Two scoring systems were utilized to assess the EMs. First, the Early Memory Aggressiveness Potential Scoring System (EMAPSS), which consists of 12 variables, was adapted from a previous pilot study. Interrater reliability was high; three naïve judges agreed 85.5% of the time, and 2 out of the 3 judges reached

consensus 95.8% of the time. Secondly, the Comprehensive Early Memory Scoring System-Revised (CEMSS-R), a general scoring system containing 65 variables that assesses both pathological and adaptive characteristics of EMs, was employed. Tobey and Bruhn (1992) cite several studies that demonstrate the reliability and validity of the CEMSS. However, because this scoring system had not been used with an aggressive, psychiatric population before, interrater reliability was computed. Individual items' interrater reliability ranged from 81.1% to 100%, and overall, the CEMSS-R raters reached agreement 94.5% of the time.

A preliminary analysis eliminated EMAPSS and CEMSS-R variables that were not sufficiently discriminatory, leaving seven EMAPSS predictor variables (someone is physically threatened, patient is psychologically abused, number of aggressive incidents, number of aggressive memories, mean severity of ratings, and maximum severity of ratings) and 13 CEMSS-R predictor variables (setting – home; sensory motor – visual, distal sensory-motor, and total sensory motor; content – trust; affect – anxiety, subject affect rating, and rater affect rating; object relations – perception of self, perception of environment, individual distinctiveness, and level of object relations; and number of words).

Results confirmed the author's first hypothesis (Tobey & Bruhn, 1992). In general, more dangerous patients recalled aggressive EMs than nondangerous

patients, $\chi^2(1, N=60)=5.62, p<.05$, remembering more physical abuse (60% vs. 42%), animal abuse (17% vs. 3%), and psychological abuse (37% vs. 3%). Specifically, dangerous patients recalled a greater number of aggressive EMs, $\chi^2(2, N=60)=8.98, p<.01$, and reported more aggressive incidents within each of their four EMs, $\chi^2(2, N=60)=9.50, p<.01$. Additionally, the severity of the aggression was rated on a 3-point scale ranging from minimal (1) to severe (3). The dangerous patients' mean severity rating and maximum severity rating significantly differed from the nondangerous patient group, with $t(51)=2.30, p<.05$ and $t(58)=2.36, p<.05$, respectively.

The second hypothesis, however, was not supported (Tobey & Bruhn, 1992). The accuracy of the EMAPSS and the CEMSS-R were analyzed using stepwise logistic regression. Both models were significant; however, the EMAPSS logistic regression model accurately classified 50% of the dangerous patients, 97% of the nondangerous patients, and 73% of the subjects overall, whereas the CEMSS-R model correctly identified 83% of the dangerous patients, 80% of the nondangerous patients, and 82% of the patients overall. Importantly, a second logistic regression analysis was run for both models in order to ascertain whether ethnic composition confounded the results. Neither the estimated coefficients for the EMAPSS nor the CEMSS-R variables significantly changed

when ethnicity was included in the model, demonstrating that ethnic composition did not adversely affect the predictive power of the rating systems.

Tobey and Bruhn's (1992) study was important for several reasons. First, the authors demonstrated that EMs can be used as an assessment tool, distinguishing specific and subtle aspects of psychopathology. Second, using two scoring systems enabled the authors to assess the potential of alternate, more specific methods of rating EMs. Although the CEMSS-R's predictive rate was slightly higher than the EMAPSS, the EMAPSS was a highly accurate means of postdictively identifying individuals at risk for aggressive behavior, and it had an extremely low false-positive rate of 6%. Finally, the interrater reliabilities calculated for both scoring systems gave credence to the fact that although EMs are subjective material, they can be accurately, consistently, and objectively evaluated.

Dependency

Exploring psychological defects and defensive ways of relating has always been an important aspect of the assessment process, specifically as it relates to the establishment of a therapeutic alliance, and dependency is an intricate construct that influences the therapeutic process in numerous ways. Based on Mayman's (1968) theory of early memories, Fowler, Hilsenroth, and Handler (1996) developed the Early Memory Dependency Probe in which an individual is asked to

recall a memory of eating, feeding, or being fed. Food was used as a symbolic representation of the "intensity of interpersonal dependency needs, presence of conflict, and the manner in which transference-related dependency conflict will likely be enacted" (Fowler et al., p. 401).

In order to test the concurrent, predictive, and discriminant validity of this projective probe, Fowler et al. (1996) compared scores on the memory to a variety of Rorschach measures and to therapists' ratings of dependent behavior in three psychotherapy sessions. The authors of this study hypothesized that the feeding/eating EM scores would significantly correlate with the Rorschach Oral Dependency Scale (ROD) and with the therapists' ratings of dependency, but would not correlate with two other Rorschach measures, the Mutuality of Autonomy Scale (MAOS) and Holt's (1977) primary and secondary aggression scores. The two latter scales were chosen in hopes of demonstrating discriminant validity.

Sixty-five inpatients (n=30) and outpatients (n=35) were recruited from psychiatric settings. Gender and ethnicity were unequally represented (women, n=48 and men, n=17; White, 94%). The mean age was 35 years, and the mean education level was 13.5 years. The majority of the sample had been in previous treatment and carried more severe diagnoses, such as characterological disorders or schizophrenia.

The following measures were utilized. First, dependency was assessed using the EM, the ROD, and the therapists' rating scale. Eight EMs were elicited, recorded verbatim, and scored for each subject. The memories were rated according to anchor points, which corresponded to three levels of dependency. A score of one was assigned if the memory contained themes of *counterdependence* (i.e., negative consequences of eating), a score of four was assigned if the memory contained themes of *mature dependence* (i.e., eating is enjoyable), and a score of seven was assigned if the memory contained themes of *anaclitic dependence* (i.e., feeding communicates painful need for succourance). Twenty EMs were randomly selected and submitted to another independent rater; interrater reliability was exceptionally high ($r = .99$).

According to the study, the ROD scale of the Rorschach measures dependent imagery and oral imagery, and has demonstrated a high degree of construct validity. The Rorschach's were scored via Exner (1986). Following this, 20 protocols were randomly selected and submitted to an independent rater. Again, interrater reliability was high ($r = .98$).

The last measure of dependency was the therapist rating scale, a 7-point scale in which psychological concepts were translated to concrete, overt behavior. For example, therapists' gave the patient a score of one if s/he made little eye contact, rejected most interpretations, and did not seem interested in therapist

comments; a score of 4 if the patient made intermittent eye contact, engaged in spontaneous interaction, and was responsive to therapist comments; and a score of 7 if the patient had sustained eye contact, was extremely obsequious, and accepted interpretations without question. Therapists' completed the scale immediately following each of the three sessions, and interrater agreement regarding the target behaviors was obtained by viewing ten random videotaped sessions (r = .82). Based on Cronbach's Alpha, the seven items on the dependency scale demonstrated a high degree of fidelity and consistency (r = .87).

The remaining two measures included the MOAS and the Holt scale, both of which were obtained from the Rorschach. The MOAS is designed to assess the developmental progression of separation-individuation, as well as the degree to which malevolent control and destructiveness are present in object relations. Holt's scale delineates two levels of aggression: level one scores are related to primitive forms, and level two responses are indicative of nonlethal forms of hostility. Both scales were reported to have adequate validity. As with the ROD scale, 20 protocols were selected at random and re-scored by an independent rater. Resulting interrater reliability correlations were high: MOAS (r = .90), Holt primary process aggression (r=.87), and Holt secondary process aggression (r=.89).

Results indicated that all three hypotheses were supported. The subjects' early memories of eating were highly correlated with the ROD (r=.55, p<.0001) and with the therapists' ratings of dependent behavior during therapy (r=.23, p<.03). In contrast, the early memories were not correlated with the MOAS (r= -8, p<.72) or the Holt primary and secondary aggression scores (r=.12, p<.34, and r=.07, p<.58, respectively). Additionally, an ANOVA was performed, contrasting the early memory scores with the MOAS, to examine possible differences in levels of pathology. Subjects whose early memories classified them as counterdependent produced significantly more pathological scores on the MOAS than any other group.

This study is significant in that concurrent, predictive, and discriminant validity for the Early Memory Dependency Probe was demonstrated. As the authors noted, although a single projective measure should never be used in isolation, eliciting an early memory revolving around feeding/eating appears to be a simple and effective way to tap into unconscious manifestations of dependency during the initial stages of treatment (Fowler et al., 1996). All research is ultimately impure and limited by sample availability; however, further research in this area might focus on obtaining a more diverse population, including other ethnicities and less severe diagnoses. Additionally, comparing this projective

measure of dependency to other objective measures of the same construct might yield a rich source of data.

Children and Adolescents

Few studies have examined the value of using early memory techniques with children and adolescents. The research that has been done, however, has found that early memory techniques can be used to distinguish between both type and level of pathology in children (Last & Bruhn, 1983; Last & Bruhn, 1985), as well as between stages of psychosocial development in adolescence (Kroger, 1990). A more in-depth examination of these findings is presented below.

Psychodiagnostic value of children's early memories. Last and Bruhn (1983) hypothesized that early memories could be used to distinguish between a pathological and a normal population of children. Specifically, the authors hoped that the Comprehensive Early Memory Scoring System (CEMSS – see Appendix A) would be more effective in identifying the degree of pathology than experienced clinicians, or than by the combined variables of age, socioeconomic status, and verbal intelligence.

Ninety-four male subjects between the ages of 8 and 12 were recruited from outpatient (44%) and inpatient (8%) psychiatric services, and from a local Boy Scout group (48%; Last & Bruhn, 1983). The mean age was 9.45 years, and

subjects were similar on variables pertaining to socioeconomic status and verbal intelligence.

The subjects were given three measures. First, the boys were asked to recall two early memories (EMs), and these were written down verbatim during the interview. These memories were independently rated, via the CEMSS, by a panel of three clinicians. The judges rated both EMs and then collapsed the data to derive a composite EM score. Interrater reliability was assessed at 92.6%. Second, the Vocabulary subtest on the Wechsler Intelligence Scale for Children – Revised (WISC-R) was used to estimate verbal intelligence. Third, diagnosis was determined by the Behavior Problem Scale of the Child Behavior Checklist (CBCL) developed by Achenbach (1978). Rated by the child's parent, this list of 118 behavioral problems is scored as zero, one, or two, depending on the degree to which they are true for the child. The authors noted that previous research has demonstrated the CBCL's reliability and validity.

The results of the statistical procedures supported all three of the author's hypotheses (Last & Bruhn, 1983). Although discriminant analyses functions were significant at the $p<.01$ level for all three EM measures, the second EM most successfully identified subjects (59% of the time) as well adjusted, mildly maladjusted, or severely maladjusted. Additionally, the CEMSS classifications were compared to those determined by three experienced child psychologists, and

the CEMSS correctly identified subjects according to their level of adjustment 49% of the time, while the mean hit rate for the clinicians was 37%. Finally, the CEMSS also outperformed a combined measure of subject characteristics and demographic variables (age, SES level, and WISC-R Vocabulary subtest score).

In 1985, Last and Bruhn expanded their 1983 study, attempting to distinguish between early memory content variables, which they proposed reflect the type of psychopathology, and structural variables, which identify the degree of psychopathology. EM content variables are defined as the "what" of memories, and examples include Characters, Settings, and Thematic Content. Structural variables, however, are the form of the early memory and include Relation to Reality, Object Relations, and Perceptions of Self.

Using a similar sample, and the same measures and procedure, Last and Bruhn (1985) used four of the CBCL's profile types, Schizoid, Somatic Complaints, Delinquent, and Hyperactive, to identify diagnostic types of psychopathology. In the multivariate discriminant analyses, significant discriminant functions ($p<.05$) were obtained for the first early memory (EM 1), the second early memory (EM 2), and the Composite EM. However, EM 1 was most effective, receiving a hit rate of 47%, as compared to the expected hit rate by chance of 25%. Schizoid subjects made the fewest references to a mother figure, but perceived themselves as able to impact a generally supportive environment.

Subjects identified in the Somatic Complaints group scored in the midrange on all variables, thus presenting a relatively unclear picture. Delinquent subjects were more concerned with fathers and viewed themselves as having little impact on an unsupportive environment. Recalling early memories at a late age (i.e., 4½ years) in which mother was present, hyperactive subjects presented themselves as effective within a supportive environment.

In Last and Bruhn's 1983 study, the only content variable that helped discriminate between levels of adjustment was the Presence of Caretaking Relatives. When the discriminant functions in the multivariate analyses of the EMs were inspected, the authors discovered that structural variables entered in each function. For example, Object Relations was entered in EM 1, and Relation to Reality was entered in EM 2 and in the EM Composite score. In contrast, in the 1985 study, Perception of Self, Presence of Mother, and Presence of Father were entered into the discriminant function for EM 1, and Perception of the Environment, Presence of Mother, and Memory Age were entered for EM Composite. These findings are noteworthy, seemingly suggesting that EM structural variables may be more effective in identifying the degree of pathology, whereas content variables may provide more information about the type of pathology.

Adolescence: Ego structuralization and ego identity status. Adolescence has been frequently described as a phase of life involving much change, cited, for example, as an "active time of psychosocial and intrapsychic reorganization" (Kroger, 1990, p. 65). Kroger sought to examine this concentrated time of change more intently by attempting to delineate phases of movement within the developmental transition from what Erikson (1968) noted was identity based on identification to identity achieved through formation.

Seventy-three late adolescents were employed as subjects with an approximately equal distribution of male (n=34) and female (n=39) participants (Kroger, 1990). Ranging in age from 19 to 22 years, the mean age for men was 20 years, 2 months, and for women, 20 years, 5 months. Two years before the study, all of the individuals had been first year university students in New Zealand. At the time of the study, 82% were still enrolled in a university, and 18% were employed, looking for work, or attending vocational training programs. In general, this appears to be an appropriate sample for the study. However, the author did note that some of the results might have been affected by the rigorous and stringent university admissions policy in New Zealand, as only about 12% of the secondary school population continues on to higher educational facilities.

The subjects were administered two measures. First, Marcia's Ego Identity Status Interview (1966) was given. Based on the clinical judgment of an assessor,

individuals were then assigned to one of four groups: (a) identity achievement, comprised of adolescents who have chosen their own values after a time of exploration; (b) moratorium, a stage in which adolescents are in the process of synthesizing childhood identifications in order to form their own identity; (c) foreclosure, in which firm psychosocial commitments have been made based on parental identifications; and (d) diffusion, described as non-committed individuals who are disinterested in exploring or finding meaningful roles or values. Two additional independent raters classified subjects according to identity status, and interrater reliability was assessed at 80%.

Second, for the early memory interview, a sequence of four memories were elicited (EM, next EM, EM of mother, EM of father). Gushurst's (1971) method for early memory interpretation was utilized as a guide for assessing thematic content, which resulted in five general themes: (a) Longing for relatedness (EM Type 1); (b) Seeking security, proximity to, or support from a significant other/familiar setting (EM Type 2); (c) Moving away from a significant other/familiar setting (EM Type 3); (d) Moving against a significant other/familiar setting (EM Type 4); and (e) Moving contentedly alone or alongside a significant other (EM Type 5). According to Kroger, previous research has demonstrated that Gushurst's approach has adequate interrater reliability and validity. Likewise,

after each memory in this study was transcribed and submitted to two independent raters, blind to subject identity status, interrater reliability was 90%.

A 2 X 4 (gender by identity status) analysis of variance was performed for each of the five early memory types, and frequency of memory type served as the dependent variable. There were no main effects for gender and no interactions. However, there were four main effects for identity status: EM Type 1, $F(3, 69)=6.21$, $p<.001$; EM Type 2, $F(3, 69)=14.21$, $p<.001$; EM Type 3, $F(3, 69)=5.16$, $p<.01$; and EM Type 5, $F(3, 69)=4.65$, $p<.01$. Post hoc comparisons were computed using Scheffé's test. EM Type 1 themes were significantly more prevalent for diffusion subjects, and EM Type 2 themes occurred more often among foreclosure subjects. Additionally, EM Type 3 themes were given significantly more often by moratoriums than by identity achievement and foreclosure subjects, and EM Type 5 themes were found significantly more often in subjects with identity achievement than by those with foreclosure status.

While previous studies have demonstrated that early memories can be effectively used for a variety of diagnostic purposes employed for example, as a tool to discriminate or identify psychopathology, this study is significant in that it seems to indicate that early memories can also be utilized as a measure of an individual's psychosocial positions and/or roles. This underscores the fact that

early memories truly seem to be selectively recollected and reconstructed, offering insight into one's current psychological organization. A limitation of this study is that only five subjects were categorized in the diffusion status. Thus, future research in this area might focus more on obtaining a more heterogeneous sample in order to examine this phase of identity more meticulously.

Normal Personality Variation and Coping

Much of the research on early memories has focused upon evaluating clinical populations and measuring psychopathology. In an important shift, however, Caruso and Spirrison (1994) designed their study to assess normal-range personality traits and coping variables in a nonclinical sample. Theoretically, the authors based their research on the view that personality is fundamentally formed via interpersonal relationships. Thus, they chose to examine early memories with the Early Memory Relationship Scoring System (EMRSS) which attempts to predict attachment style, mood, and clinical symptomatology. Specifically, Caruso and Spirrison focused on a 6-item composite scale of the EMRSS, called the EM Relationship Scale, designed to assess the nature, quality, and level of object relations in a subject's EMs.

The study had two objectives. First, Caruso and Spirrison (1994) were interested in discovering whether the EM Relationship Scale could be used to assess neuroticism and coping ability in a nonclinical population. Secondly, the

authors hoped to demonstrate that the EM Relationship Scale was a central EM dimension, thus accounting for a large amount of the overall variance seen in EM responses.

One hundred thirty-four subjects participated in the study, all of which were undergraduates (Caruso & Spirrison, 1994). There were more women (n=86) than men (n=48), and the range of age was large (18–47). The authors did not address other important demographic variables such as socioeconomic status, intelligence, or marital status, all of which have been associated with EM differences (Davidow & Bruhn, 1990; Last & Bruhn, 1983).

In terms of measures, Caruso and Spirrison (1994) requested that subjects write down their earliest memory, and included follow up questions related to associated feelings, age, and pleasantness or unpleasantness of the incident, reminiscent of Mayman's (1968) approach. This memory was scored using two rating systems. As mentioned above, the EMRSS, a 24-item scoring system, notes the presence or absence of attempts at mastery, caregiver interactions, and peer/sibling interactions and, within each theme, rates the memory with a 5-point likert scale on nature, outcome, coherence, feelings, and view of self, others, and the environment. The Transparent Bipolar Inventory (TBI) was also used to rate the memory. The TBI is composed of 35 pairs of opposite adjectives, 7 of which correspond to the five personality factors (Extraversion, Pleasantness,

Conscientiousness, Emotional Stability, and Intellect). It was hypothesized that using the TBI would provide a basis from which to rate normal personality variation.

Additionally, subjects were administered the Revised NEO Personality Inventory (NEO-PI-R) and the Constructive Thinking Inventory (CTI; Caruso & Spirrison, 1994). The authors noted that there is empirical support for the internal structure and external validity of NEO-PI-R, a 240-item test that assesses five dimensions of personality (Neuroticism, Extraversion, Openness to Experience, Agreeableness, and Conscientiousness). The CTI, which consists of 108-items, is meant to evaluate patterns of everyday thinking that are automatic and habitual.

The results of this study pertain to interrater reliability, significant correlations between scoring systems and measures, and factor analyses. First, in terms of interrater reliability, intraclass correlation coefficients were computed for the EMRSS (all but three items exceeded .70), the EM Relationship Scale (.83), and the five TBI domain scores (all but Intellect exceeded .70). Secondly, there were three significant correlations between the scoring systems and the measures. The EM Relationship Scale was significantly correlated with two CTI scales, Personal Superstitious Thinking, $r(132)= -.17$, $p<.05$, two-tailed, and Categorical Thinking, $r(132)=.21$, $p<.05$, two-tailed, and the TBI Pleasantness domain was

found to be significantly correlated with the NEO-PI-R Agreeableness domain, $r(132)=.17$, $p<.05$, one-tailed (Caruso & Spirrison, 1994).

Finally, two exploratory factor analyses were conducted. Four factors, EM Tone, Social Interest, Peer Relations, and Self-Efficacy, accounted for 76.9% of the variance on the EMRSS, while three factors, Emotional Poise, Activity, and Dependability, explained 75.4% of the variance on the TBI. Subsequent to these analyses, correlations between the seven factors were calculated. The strongest correlations were between EMRSS Factor 1 (EM Tone) and TBI Factor 1 (Emotional Poise), $r(132)=.76$, $p<.001$, and between EMRSS Factor 4 (Self-Efficacy) and TBI Factor 2 (Activity), $r(132)=.62$, $p<.001$ (Caruso & Spirrison, 1994).

Although Caruso and Spirrison's (1994) study did yield significant correlations indicating, for example, that the EM Relationship Scale was inversely related to destructive thinking patterns, the correlation coefficients tended to be small. As the authors noted, this may be due to the fact that they collected only one EM from each subject. This author wonders if the small correlations could have been an indication that assessing health is more difficult than assessing unhealth; that is, perhaps psychopathology provides a wider range of variance. Nonetheless, further research using EMs to assess normal personality variation and coping ability might focus on obtaining a series of EMs. In addition,

longitudinal studies might provide a rich set of data in which to explore changes or adaptations in personality and coping abilities.

The Importance of Age

Data regarding the impact of age at earliest memory has been somewhat mixed, and the last two articles that will be reviewed in this section are representative of this conflict. Repression suggests an inability to remember significant early events due to external interference and has traditionally been associated with a greater level of pathology (Parks & Balon, 1995). Using this theoretical framework, individuals who were traumatized would report memories that occurred at a later chronological age. More recently, however, theorists have proposed that individual's who report remembering events that occurred at an older chronological age would show evidence of greater emotional stability and fewer propensities to engage in fantasy (Spirrison et al., 1997). A discussion regarding the ways that the data can be reconciled is presented at the end of the reviews.

Age and alleged childhood trauma. The association between severe trauma and memory disorders has long been noted in the literature, and several theories, such as repression and dissociation, have been posited (Parks & Balon, 1995). In an attempt to understand the intricate results of trauma upon memory more thoroughly, Parks and Balon investigated the effect of a history of alleged

childhood trauma upon the retrieval of early memories. Specifically, the authors of this study predicted that adults with alleged trauma would show evidence of memory limitations, including a greater number of retrieval failures in response to stimulus cues, an increased latency response, a recency effect in the temporal distribution of memories, and a later mean age of earliest memory.

Three groups of subjects were employed by Parks and Balon (1995). The alleged trauma group (n=20) consisted of 14 females and 6 males, who ranged in age from 20–54 years and had a mean education level of 15.4 years. Trauma was defined as physical abuse or sexual abuse (n=15), chronic alcohol or drug dependence of one or both parents (n=2), and psychological terrorism or severe neglect (n=3). Including 17 participants, a patient control group was recruited to correspond to the trauma group in terms of gender, age (M=38.3), and education level (M=16.3 years). A nonpatient control group (n=20) was also solicited to correspond to the demographics of the trauma group, resulting in a group with a mean age of 38.6 years, and a mean education level of 15.9 years. All of the subjects were White suburban residents. Although the trauma group appears to be relatively homogeneous, the sample otherwise appears to be an appropriate selection for this study.

The subjects were administered three measures. First, the Logical Memory subscale of the Wechsler Memory Scale – Revised (WMS-R) was administered to

assess verbal memory and to establish group equivalence on this dimension. Second, the word-cueing technique, which includes the use of object, activity, and affect words, was employed. Finally, the Early Memory Test (EMT) was given, in which subjects were asked to recall a series of eight memories including their earliest memory, next earliest memory, earliest memory of mother, next earliest of mother, earliest memory of father, next earliest of father, earliest happy memory, and earliest unhappy memory (Parks & Balon, 1995).

Results indicate that the three groups were equivalent with regard to immediate and delayed verbal memory, establishing the fact that the trauma group was not organically impaired. A repeated measures analysis of variance indicated that the trauma group had more retrieval failures than the patient and the nonpatient subgroups, $F(2, 54)=7.78$, $p<.001$. Specifically, the trauma group failed more often to retrieve an early memory when cued by affective words, $F(4, 108)=3.23$, $p=.015$. The second hypothesis was also supported; the trauma group took longer to respond to the cues than the other two groups, $F(2, 54)=7.15$, $p<.002$. Additionally, the patient and nonpatient control groups temporally distributed more memories during earlier phases of their lives than the trauma group, $F(4, 54)=3.52$, $p<.037$. Finally, results also included the fact that the groups differed in terms of mean age of earliest memory, $F(2, 54)=6.38$, $p<.003$).

A Tukey HSD test revealed that the nonpatient group recalled memories at a younger mean age than the trauma group (Parks & Balon, 1995).

Parks and Balon's (1995) study underscored the fact that external factors influence memory processes and was important because the EMT demonstrated an ability to distinguish between groups based on age of earliest memory. This author believes that it is important to continue researching the relationship between early memories and trauma, inquiring further into such aspects as pre- and post-treatment effects, level of attachment, and length of trauma. In addition, it would also be interesting to perform qualitative analyses on the EMs obtained from patients reporting a history of childhood trauma, as this would likely provide information about relational dynamics for treatment purposes.

Age and maladjustment. In a previous study, Caruso and Spirrison (1994) found that subjects who recalled early memories that occurred at an early chronological age evidenced a greater amount of distorted patterns of thinking and, conversely, that subjects who recalled early memories at a later chronological age were less prone to fantasy. In a continuation of this research, Spirrison et al. (1997) posited, in contrast to Parks and Balon's (1995) study, that individuals with an inability to recall early childhood events would report greater emotional stability.

Sixty participants were recruited from an undergraduate university. Gender equality was established (32 women and 28 men), but some ethnic minorities were underrepresented (45 Whites, 14 African Americans, 1 Hispanic American). The mean age was 19.72 years. Using a modified version of Mayman's (1968) early memory form, subjects were asked to recall one early memory. Memories were scored with the Transparent Bipolar Inventory, which was demonstrated to have adequate interrater reliability in a previous study (Caruso & Spirrison, 1994).

Four other measures were completed: the Marlowe-Crowne Social Desirability Scale, a 33-item true-false scale designed to assess a tendency toward giving socially acceptable responses; the Rotter Incomplete Sentence Blank, which was scored as an index of general maladjustment; the Symptom Checklist-90-Revised, which assesses the extent to which specific symptoms cause discomfort; and the Wahler Physical Symptoms Inventory, a 42-item test assessing common somatic complaints. Three raters scored each early memory and the Rotter Incomplete Sentences Blank. Interclass correlation coefficients associated with the three main scales of the TBI, Emotional Poise, Activity, and Dependability, were assessed at .92, .62, and .56 respectively, while the Rotter Incomplete Sentences Blank data yielded an interclass correlation coefficient of .91.

Age of earliest memory was used to form three groups, those that reported their earliest memory occurred prior to age 4 (n=18), at ages 4 through 5 (n=24),

and after 5 years of age (n=18). A *priori* two-tailed t test revealed that subjects who reported an early memory that occurred prior to the age of 4 scored significantly higher on the Rotter Incomplete Sentences Blank than participants with later memories (t_{34}=2.19, p=.04). A MANCOVA was run, with sex and the three age groups as independent variables, and the Rotter Incomplete Sentences Blank, and the Wahler Physical Symptom Inventory serving as dependent variables. The scores for the Marlowe-Crowne were added as a covariate. Results indicate that the dependent variables were affected by age, F(6, 102)=2.80, p=.02). The group main effect for age was only significant for the Rotter Incomplete Sentences Blank, F(2, 54)=5.52, p=.007).

In a summary statement, Spirrison et al. (1997) claim, "Age at reported earliest memory was significantly related to maladjustment, with persons reporting first memories prior to age four years of age having significantly higher scores on maladjustment, as measured by the Rotter Incomplete Sentences Blank, than individuals with first memories occurring later" (p. 227). In contrast, Parks and Balon (1995) reported, "The alleged trauma group reported fewer early memories…[the] mean of earliest memories was chronologically older than the mean of the nonpatient control group" (p. 206).

Several factors may account for the discrepancies between data. First, Spirrison et al. (1997) and Caruso and Spirrison (1994) used a nonclinical

population for their research, while Parks and Balon (1995) used a clinical population. Secondly, trauma does not necessarily denote pathology; thus, perhaps some of the terms in both studies have not been clearly and consistently defined. Finally, it is unclear at this time whether the Rotter Incomplete Sentences Blank is the best measure of maladjustment. Further research might improve upon these methodological considerations.

Discrepancies Between Objective and Projective Data

Discrepancies between objective and projective assessment data have long been noted in both laboratory and clinical settings. For example, in two studies women scored higher on objective measures of pathology (Bornstein, Bowers, & Robinson, 1995; Tanaka-Matsumi & Kameoka, 1986); however, when projective measures of the same construct were used, gender effects disappeared (Bornstein et al., 1995).

These discrepancies have led some to disregard the value of projective assessment, producing lively discussions and debates in psychological journals. In replying to Riethmiller and Handler's (1997) support of the use of projective drawings in clinical assessment, Joiner and Schmidt (1997) state:

> [they] then imply that we are defeatist, conceptually uninformed, and reactionary. They have made a drawing of us, our experience-near

> interpretation of which we do not like. Happily, this drawing, like the drawing indices from our original article, is invalid (p. 479).

In a cursory review of current introductory psychology textbooks, Masling (1997) noted that projective tests are reviewed in a negative manner, as if "clinicians were still reading tea leaves" (p. 263).

Several reasons for the discrepancies between objective and projective data have been posited. Viglione (1996), in attempting to reconcile data between the MMPI and the Rorschach, suggested that while the Rorschach may be a measure of the internal world, the MMPI might better assess the interaction between the environment and behavior. Others have proposed that projective tests tap into early affective experiences, thus measuring implicit, unconscious motives associated with long-term spontaneous behavioral patterns (Cramer, 1999; Masling, 1997; Riethmiller & Handler, 1997). In contrast, objective data, or self-report measures, assess behavior that is conscious, immediate, and situationally specific.

This latter hypothesis received support in Bornstein et al.'s (1995) work in which projective measures of dependency predicted the subjects' frequency estimates and impact ratings of interpersonal life events. Eighty-three undergraduate subjects (58 women and 25 men) were assessed by an objective measure of dependency, the Interpersonal Dependency Inventory (IDI), and a

projective measure of dependency, the Rorschach Oral Dependency scale (ROD). Subsequently, during a three-month period, the subjects provided monthly reports on the frequency and impact of various types of life events, such as interpersonal events (i.e., broke up with significant other), achievement events (i.e., failed an exam), and financial events (i.e., lost a wallet), using the Life Events Inventory (LEI).

Results indicated that the ROD scores positively correlated with the number of interpersonal events reported by the subjects and negatively correlated with the subjects' impact ratings, while no significant correlations were obtained between subjects' IDI scores and life event frequency and impact. In discussing these results, Bornstein et al. (1995) noted that, "projective measures of traits and motives are strong predictors of spontaneous behavioral trends exhibited over time and across situation, whereas objective measures show greater predictive validity in highly structured laboratory situations" (p. 265). Furthermore, the authors of this study suggested that perhaps objective measures capture a proportion of an individual's self-presentation needs in addition to or in lieu of their self-reports of cognitions, motivations, or emotional responses.

This author believes that it is important to emphasize that both projective and objective tests are valuable, and that the discrepancies between the two sets of data are often interesting and psychodynamically meaningful (Riethmiller &

Handler, 1997). It is clear, however, that reliance upon self-report measures is increasingly being questioned, particularly as there is something "logically inconsistent about asking people to self-report on aspects of their personality that are, by definition, generally inaccessible to consciousness" (Cramer, 1999, p. 84; Karliner et al., 1996). In addition, self-presentation or social desirability may impact self-report tests more significantly than projective measures. The following two landmark studies investigate this assertion more thoroughly and underscore the fact that assigned meaning is ultimately a function of clinical judgment, whether data is obtained via self-report or projective means.

Reliance Upon Self-Report Measures Questioned

Tanaka-Matsumi and Kameoka (1986) investigated the reliability and concurrent validities of self-report measures of depression and anxiety, and assessed the extent to which these tests were related to social desirability. The authors recruited 391 college students (135 males and 256 females) and administered a battery of 11 questionnaires in standardized small group sessions.

Measures included: (a) three depression inventories, including the Beck Depression Inventory (BDI), the Zung Self-Rating Depression Scale (Zung-D), and the Lubin Depression Adjective Checklist – Form B (DACL); (b) six anxiety questionnaires, including the Zung Self-Rating Anxiety Scale (Zung-A), Spielberger State and Trait Anxiety Inventories (SAI and TAI), the Taylor

Manifest Anxiety Scale (MAS), and the S-R Inventory of Anxiousness (EHS/EHE); and (c) two tests of social desirability, including the Edwards Social Desirability Scale (ESDS) and the Marlowe-Crowne Social Desirability Scale (MCSDS). It is important to note that the ESDS consists of 39 true-false items taken from the MMPI, whereas the MCSDS, a 33-item scale, does not include many pathology related items.

Results included findings related to reliability, validity, and social desirability. First, Tanaka-Matsumi and Kameoka (1986) computed alpha coefficients for each measure. Each scale achieved satisfactory levels of internal consistency, demonstrating that the questionnaires were reliable.

Second, intercorrelations of the 11 measures were calculated in order to examine convergent and discriminant validities. The three correlations between the measures of depression and the six correlations between the measures of anxiety were all significant, indicating convergent validity. However, the scores on the measures of depression and anxiety were also highly correlated, and thus, discriminant validity was not established. For example, the Beck Depression Inventory correlated more highly with measures of anxiety, such as the Taylor Manifest Anxiety Scale, $r(389)=.71$, $p<.001$, than with other scales measuring depression (Tanaka-Matasumi & Kameoka, 1986).

Finally, the two scales of social desirability were considered. The ESDS correlated significantly and negatively with all of the depression and anxiety scales. In contrast, the MSCDS's correlations were relatively low; none of the nine measures correlated higher than -.32 (Tanaka-Matasumi & Kameoka, 1986).

This study is important in that it critically evaluated the way in which researchers and clinicians have relied upon self-report inventories. Due to the high correlations between the measures of depression and anxiety, Tanaka-Matsumi and Kameoka (1986) demonstrated that differentiating pathology on the basis of self-report is problematic at best and unethical at worst. In addition, the authors also uncovered an interesting finding in terms of social desirability. The results of the correlations between the ESDS and the measures of depression are consistent with cognitive models; that is, a depressed individual presents himself or herself in a negative light. However, the results of the correlations between MCSDS and measures of depression indicate that further research is needed to ascertain what happens when response style is measured independently of pathology content.

Illusory Mental Health

In 1993, Shedler, Mayman, and Manis introduced and expounded upon the term "illusory mental health" in a series of three studies. Based on the psychoanalytic notion of unconscious processes and defenses, Shedler et al. (1993)

proposed that individuals who score in the healthy range on mental health scales could be divided into two subgroups, those who are genuinely healthy and those who are psychologically distressed but present with an illusion of mental health via defensive denial. This defensive process is associated with physiological stress and illness.

In addition, the authors predicted that clinical judges could distinguish between genuine and illusory mental health while objective mental health measures could not. The authors base this assumption upon the fact that:

> Human communication can convey multiple levels of meaning beyond its face value or manifest content, that these meanings emerge most readily when communication is not overly structured, and that another human being is the best (as of now, perhaps the only) 'instrument' for registering these meanings (Shedler et al., 1993, p. 1118).

The research design in each of the three studies was similar. Subjects were administered a standard self-report measure of general mental health, the Eysenck Neuroticism scale in the first two studies, and the Beck Depression Inventory (BDI) in the third study. Subjects also completed the Early Memory Test, which asked for their earliest memory, earliest memory of mother, earliest memory of father, earliest happy memory, earliest unhappy memory, a memory "in which you feel most fully yourself," and "the most active early memory you can think of."

Clinical judges independently and blindly rated the memories. Subsequently, subjects were classified into three groups. *Genuine health* was designated when self-report and clinical judgment concurred in indicating health, *illusory mental health* was designated when subject's self-report indicated health but clinical judgment indicated distress, and *manifestly distressed* was designated when both subject's self-report and clinical judgment indicated distress.

Subjects were then exposed to three tasks designed to elicit stress in a laboratory session while their heart rate (HR), systolic blood pressure (SBP), and diastolic blood pressure (DBP) were measured (Shedler et al., 1993). The first task consisted of seven arithmetic problems from the Wechsler Adult Intelligence Scale, while the second task required subjects to tell stories to five Thematic Apperception Test (TAT) cards (Cards 1, 7GF, 13MF, 18GF, and 13B). The final measure was a phase association task designed to assess verbal defensiveness. Subjects were asked to respond with the first thing that came to mind after the examiner read fourteen neutral phrases, seven aggressive phrases, seven dependency phrases, and seven sexual phrases. Verbal defensiveness was coded if a subject made an attempt to avoid the content of the stimulus phrases, such as, misinterpreting the phrase, asking the examiner to repeat the phrase, or beginning but failing to complete a response.

In the first study, 58 subjects were recruited from the University of Michigan. There were 25 male and 33 female participants, and they ranged in age from 17 to 47 (M=21.5 years). After comparing the self-report measures against clinical judgment, 9 subjects were classified as genuinely healthy, 18 as having illusory mental health, and 11 as manifestly distressed. Significant results include the fact that the illusory mental health group showed greater physiological reactivity than the genuinely healthy group, $t(25)=2.76$, $p=.01$, two-tailed, and the manifestly distressed group, $t(27)=2.29$, $p=.03$, two-tailed. In addition, the illusory mental health group gave more verbal manifestations of defensiveness than the genuinely healthy group, $t(24)=2.24$, $p<.05$, two-tailed, and the manifestly distressed group, $t(26)=2.08$, $p=.05$, two-tailed (Shedler et al., 1993).

A final test was done to assess the effect of clinical judgment. The Neuroticism scores were correlated with a measure of reactivity for the genuinely healthy group and the manifestly distressed group. The correlation between neuroticism and physiological reactivity for the distressed group was significant, $r(27)=-.48$, $p<.005$, while the correlation for the genuinely healthy group was not significant. These two correlation coefficients significantly differed from one another, $z = 1.99$, $p<.05$, two-tailed, indicating that clinical judgment is a moderating variable, changing the relationship between Neuroticism scores and physiological reactivity (Shedler et al., 1993).

In the second study, two panels of undergraduate students replaced the clinical judges. This was done in an effort to examine the strength of subjective human judgment and the value of the EMT as an assessment tool. The student judges received basic instructions and, based on the EMT, evaluated each subject on a 7-point scale ranging from extremely unhealthy to extremely healthy. The student-judge ratings were aggregated, creating a composite mental health rating for each panel. Alpha reliabilities for these composites were .92 and .94 for Panels 1 and 2, respectively, and correlations between the clinician and the composite ratings were .50 and .62 for Panels 1 and 2, respectively (Shedler et al., 1993).

Using the Panels' clinical ratings as a basis for subject classification, the results again showed that the illusory mental health group showed greater physiological reactivity and verbal defensiveness than either the genuinely healthy or the manifestly distressed group. In addition, it was again demonstrated that clinical judgment reverses the relationship between self-report and physiological reactivity (Shedler et al., 1993).

In the third study, a larger sample, consisting of 74 subjects, was used to replicate the findings. Sixteen subjects were classified as genuinely healthy, 21 as having illusory mental health, and 13 as manifestly distressed. The results remained the same (Shedler et al., 1993).

As in the Tanaka-Matsumi and Kameoka (1986) study, Shedler et al.'s (1993) results call objective measures of mental health into question and suggest that they are particularly ambiguous when they assess an individual as healthy. In response to individuals who manifest positive illusions and, thus, look healthy on self-report measures, Shedler et al. state, "The most straightforward conclusion is that people who are prone to distort also give distorted responses to mental health scale items, and their scores simply cannot be taken at face value" (p. 1128). In addition, Shedler et al.'s results give clear support and credence to the use of clinical judgment.

The Need for Projective Spiritual Assessment

Although the intensity, method, and degree of emphasis has varied during the course of human history, most generations and cultures have acknowledged a spiritual dimension of reality beyond the earth, unaffected by limitations pertaining to intellect or tangible sensory experience (Gorsuch & Miller, 1999). However, psychology has historically maintained an uneasy relationship with spirituality, beginning with Freud, who suggested that religion was a universal neurosis and that God was nothing but an illusory father created out of anxiety and hopelessness (Freud, 1907/1959; Freud, 1927/1961).

Though Jung and object relations theorists challenged Freud's views, presenting a more positive view of the human desire to relate with God (Brokaw & Edwards, 1994), the discipline of psychology continued to neglect the importance of spirituality. For example, it was not until 1992 that the Ethical Principles of Psychologists and Code of Conduct included religion as a human difference (Hall, Tisdale, & Brokaw, 1994). In addition, there was no method for clinicians to categorize religious or spiritual problems until the fourth revision of the Diagnostic and Statistical Manual for Mental Disorders (Hall & Edwards, 1996).

These changes within the field of psychology, however, were monumental, reflecting the resurgence of interest in spirituality in contemporary culture (Gorsuch & Miller, 1999; Richards & Bergin, 1997), and underscoring the need for psychologists to respond by effectively assessing and sensitively treating patients with religious beliefs. As efforts to integrate the spiritual side of human nature into the psychological arena are increasingly being made, the need for spiritual assessment has become apparent.

Although a multitude of measures to assess spiritual constructs have arisen in response to this need (Gorsuch & Miller, 1999; Hill & Hood, 1999), spiritual assessment is still in its infancy (Richards & Bergin, 1997). Spirituality, like personality, is complex. With many caveats, nuances, definitions, and methods of expression, spirituality and religiosity are difficult to measure. Richards and

Bergin, for example, cite nine dimensions of spirituality that need to be assessed including an individual's metaphysical worldview, religious problem solving style, God image, doctrinal knowledge, and spiritual health or maturity.

Thus, there is much work yet to be done in theory, research, and practice. In order to provide a framework for this work, it is first necessary to clearly articulate the reasons for conducting spiritual assessment. Subsequent to this, a rationale for projective spiritual assessment will be provided, followed by a review of the current projective measures available. The final section will include a discussion on the emerging use of early memories in projective spiritual assessment.

Reasons for Spiritual Assessment

There are several reasons, irrespective of the ebb and flow of contemporary interest, for psychologists to routinely engage in spiritual assessment. First, assessing spirituality provides a greater understanding of the patient and his/her worldview and allows the clinician to proceed with sensitivity (Gorsuch & Miller, 1999; Richards & Bergin, 1997). Gorsuch and Miller (1999) suggest that spirituality influences prognosis in a variety of ways, and assessment is necessary to determine if a patient's belief system serves as a protective influence or has a detrimental effect. In addition, a spiritual assessment can produce information

regarding the patient's ability to utilize beliefs and community resources for coping purposes.

Because treatment can affect spiritual functioning, it is necessary to understand which spiritual variables may be moderators of change and to examine which interventions could be used in psychotherapy to increase spiritual maturity (Gorsuch & Miller, 1999; Richards & Bergin, 1997). Finally, without conducting a spiritual assessment, clinicians are potentially unaware of whether patients have unresolved spiritual doubts or concerns that need to be addressed. As Richards and Bergin (1997) succinctly state:

> It is not desirable for therapists to compartmentalize the different systems of human functioning and work only on psychological and interpersonal issues with clients. To help clients resolve their emotional and interpersonal problems, therapists may frequently need to help clients address their spiritual issues (p. 175).

Rationale for Projective Spiritual Assessment

In a review of *Measures of Religiosity*, a resource for spiritual assessment edited by Hill and Hood (1999), this author found 3 structured interviews, 3 projective measures, and 120 objective measures. Although there are clearly a plethora of objective spiritual measures available, assessing a variety of religious dimensions, validity has not been satisfactorily demonstrated for most of these

tests. In addition, it appears apropos to assert that there is an increasing and somewhat urgent need for projective spiritual assessment, particularly in light of the doubts that have been cast on the reliability and validity of traditional self-report measures (Shedler et al., 1993; Tanaka-Matsumi & Kameoka, 1986).

While some have argued that new spiritual measures should not be developed until the current tools are researched, validated, and understood (Gorsuch & Miller, 1999; Hill & Hood, 1999), this does not seem to be an appropriate caution for projective tests for several reasons. First, as noted earlier, the discrepancies between objective and projective data have historically suggested that the two procedures are measuring distinct and somewhat separate domains. It seems important that clinicians have a way in which to assess an individual's internal spiritual world, unconscious spiritual motives, and early affective spiritual experiences, as these may give insight into long-term spontaneous behavioral patterns.

Second, up until this point, researchers and clinicians have almost exclusively been relying upon objective spiritual measures. Because self-report tests do not always measure what they claim to assess (Tanaka-Matsumi & Kameoka, 1986), this severely limits available data, and the potentially rich spiritual information about a patient is left untapped. Finally, projective measures usually rely upon some form of clinical judgment, which has been shown to be a

crucial factor in discriminating genuine mental health from illusory mental health (Shedler et al., 1993). It appears essential that the use of clinical judgment also be extended into the spiritual realm, allowing researchers and clinicians alike to assess spiritual health independent of defensiveness and self-desirability.

Review of Current Projective Spiritual Measures

Formal attempts to engage in projective spiritual assessment began with Ana-Maria Rizzuto (1979), who formulated clinical interpretations based on her patients' drawings of God. One picture, called "A God in the Mirror," depicted the patient facing forward toward a mirror that reflected back the image of God. Rizzuto suggested two things: first, that the patient wondered whether or not God existed and second, that his drawing was representative of the psychoanalytic anal-retentive phase in which there is narcissistic ambivalent attachment to an object. This landmark case study, along with four others, are reported in *The Birth of the Living God* and give information about the development of one's God concept as well as the impact that significant others have upon one's God representation.

Rizzuto went on to develop the God and Family Questionnaires, based on psychoanalytic, object relations, and self-psychological theories of development (Hill & Hood, 1999; Hall et al., 1994). This measure was designed to assess an individual's internal images of self, others, and God. In a manner similar to sentence completion tasks, the God Questionnaire consists of 45 sentence stems,

and the Family Questionnaire includes 23 sentence stems, each of which query for an individual's experience of God and family. Interpretation rests upon clinical judgment, and there are no standardized criteria for scoring to date. Although the questionnaires appear to have high face validity, there are no normative, reliability or validity data available (Hill & Hood, 1999).

A Nonverbal Measure of God-Concept was developed by Bassett and his colleagues in 1990 and revised in 1994 (Hill & Hood, 1999). Based on Piaget's stages of cognitive development, this measure attempts to identify the differences in conceptions of God related to levels of cognitive maturity. A series of realistic and symbolic drawings are presented to the subject who is asked to choose the ones that most remind them of God. The rationale for a nonverbal measure of God concept is clear in that it allows for assessment with culturally diverse populations, including those with restricted language skills. However, there are several limitations to this test, such as its lack of demonstrated validity and reliability (Hall et al., 1994).

In 1993, Saur and Saur produced The Spiritual Themes and Religious Responses Test (STARR), a projective measure designed to elicit unconscious spiritual material related to an individual's experience of God. Similar to the Thematic Apperception Test (TAT), 11 black and white stimulus cards that depict photographs of people in prayerful postures are presented to the subject (Hill &

Hood, 1999). In Instructional Set I, the subject is asked to tell a story with a beginning, middle, and end as well as to provide information on what the main character is thinking and feeling. In Instructional Set II, the subject is told to make up or describe a prayer in an effort to gather more specific information about his/her relationship with God. There are two limitations to the STARR. First, standardized methods of administration and scoring have not been developed (Hall et al., 1994), and second, normative, reliability and validity data are all limited.

Clearly, these three projective spiritual techniques vary in purpose and scope. The lack of standardized norms, as well as studies establishing reliability and validity, are also evident. A caution is warranted. As new projective measures are developed, it is important to not neglect to produce research that would strengthen these measures. In addition, new projective spiritual measures should be developed with caution and thought, carefully considering the nature and purpose of the test, investigating how to incorporate standardized scoring methods, and making an effort to produce data relating to reliability and validity.

Revisiting Early Memories

In an effort to respond to the rising interest in spirituality amongst psychologists, and in an attempt to provide a projective measure of spirituality that would distinguish between genuine and illusory spiritual health, the Early Spiritual Memory Test (ESMT) was developed (Lin et al., 2000). The ESMT varies only

slightly from the EMT, asking for an individual's earliest and next earliest spiritual memory, earliest spiritual memory with a significant other, and earliest spiritual memory of God.

A preliminary investigation was conducted to assess whether the ESMT was a reliable and valid measure, specifically pertaining to three research questions (Lin et al., 2000). First, the authors desired to explore the subjects' qualitative responses to the task. Second, because it was necessary to demonstrate the reliability of the ESMT, alpha coefficients and interrater reliabilities were calculated. Third, the authors wished to address the relationship between the EMT and the ESMT as well as their relationships to instructor ratings on two dimensions of spirituality.

The sample consisted of 108 graduate students enrolled in a southern California seminary (Lin et al., 2000). Subjects were asked to complete both the EMT and the ESMT in a written format, and two independent raters, blind to corresponding early memory data, scored the narrative responses based on the AEMI scoring criteria. Instructor ratings were utilized to rank subjects along two spiritual dimensions: level of awareness of God and quality of relationship with God (Hall & Edwards, 1996).

In terms of qualitative results, the authors noted that both the EMT and the ESMT narratives were similar in terms of length (quantity) and depth (quality)

(Lin et al., 2000). Quantitatively, four alpha coefficients were calculated to determine the validity for each rater on each instrument, all of which were significant (α for rater 1 on EMT = .9685, α for rater 2 on EMT = .9700, α for rater 1 on ESMT = .9250, and α for rater 2 on ESMT = .9287). Interrater reliability for the EMT and ESMT data were significant, r=.899, p<.001, two-tailed, and r=.840, p<.001, two-tailed, respectively. However, there was no correlation between EMT and ESMT scores, indicating that the ESMT was measuring something different from the EMT. Additionally, the EMT and ESMT scores correlated with the instructor's perception of the subject's quality of relationship with God, r=.521, p<.05, two-tailed, and r=.366, p<.05, two-tailed, respectively.

A second study with a similar procedure was conducted to further evaluate the ESMT (Lin et al., 2001). Using an expanded sample, which consisted of 74 seminary graduate students and 81 undergraduate students, the subjects were again asked to provide written responses to the EMT and the ESMT. The objective of this second study was to obtain further information regarding ESMT reliability and validity and to begin to examine the narratives of the spiritual memories more closely.

In order to do this, qualitative analysis was conducted by separating the data into four cells based upon the EMT and ESMT ratings given for each subject

(i.e., high EMT-high ESMT, high EMT-low ESMT, low EMT-low EMST, low EMT-high ESMT). Textual analysis was performed on the memory content of subjects whose EMT scores were clearly divergent from or similar to their corresponding ESMT scores (i.e., high EMT-low ESMT and low EMT-high ESMT were considered divergent, and high EMT-high ESMT and low EMT-low ESMT were considered similar).

Results demonstrated that the alpha coefficients for both raters on the EMT and the ESMT narratives from both sub-populations were significant, indicating internal consistency for each rater (Lin et al., 2001). In addition, interrater reliability for EMT and ESMT data from both sub-populations was significant, and there was no significant correlation between the EMT and the ESMT, replicating the preliminary study's results.

Most interestingly, textual analysis revealed that subjects with low EMT-high ESMT ratings reported early memories of poor attachment or abandonment issues, under-protection or unjust punishment by caregivers, instability of the home environment, negative self-perception, and feelings of fear, insecurity, sadness, and loneliness. Corresponding early spiritual memories contained themes of loving and reliable relationships with God and spiritual mentors, protection from God or other spiritual figure, improved self-concept, and feelings of assurance, happiness, and emotional connection with others. Those subjects who

fell into the high EMT-low ESMT cell reported a distinct reversal of themes, seemingly indicating that healthy, stable childhood experiences can be associated with subsequent negative or unhealthy spiritual experiences (Lin et al., 2001).

Similar to Kirkpatrick and Shaver's (1990) compensation hypothesis, which suggests that religion provides a surrogate attachment for individuals with insecure early attachments, the data suggests that subjects who received low EMT-high ESMT ratings were reporting spiritual experiences that compensated for basic emotional and attachment needs that went unmet in childhood. While previous studies have used self-report measures to establish a significant relationship between the level of object relations development and God image (Brokaw & Edwards, 1994), Lin et al.'s (2001) study was the first to utilize clinical judgment to assess issues of spirituality and mental health.

These early spiritual memory studies are significant for several reasons. Most obviously, the development of the ESMT is important in that it is a projective measure of spirituality. Second, the lack of correlation between the EMT and the ESMT support the notion that spiritual memories are obtainable and are revealing something different and new. Lin et al.'s (2000, 2001) studies also serve to further validate the use of the AEMI as a standardized scoring system for early memories. Finally, the use of clinical judgment to assess an individual's level of health has been extended into the spiritual arena. Further research might

focus on obtaining a more heterogeneous sample, including other religious/faith populations, and on continuing to qualitatively examine spiritual memories.

Conclusion

The purpose of this paper was to demonstrate the clinical utility of early memories by reviewing the current literature and to provide a rationale for extending this technique into the spiritual arena by highlighting the lack of available projective spiritual measures. A framework for understanding the literature was provided by reviewing important early memory theories, including the contributions of Sigmund Freud, Alfred Adler, ego psychology, cognitive-perceptual theory, and Martin Mayman. In addition, various early memory techniques and pertinent rating systems, such as the Early Memory Test (EMT) and the Adelphi Early Memory Index (AEMI) were presented.

The literature review on early memories uncovered clinical information related to the variables of alcoholism, suicide, the criminally dangerous, dependency, children and adolescents, normal coping, and age. Specifically, the following five key concepts emerged.

First, the research demonstrated that early memory techniques have successfully been used to distinguish between types and levels of pathology. Chaplin and Orlofsky (1991) compared EMs of alcoholics with a non-alcoholic

control group. They found that alcoholic EMs were significantly different, containing more immature psychosocial themes, more negative affect, and more passive content. In contrast, the EMs of the control group showed more evidence of social interest, maintained a healthy self-concept, and had an internal locus of control. Tobey and Bruhn (1992) revealed that dangerous psychiatric patients recalled a greater number of aggressive EMs than nondangerous patients, demonstrating that EMs may be used to identify individuals at risk for aggressive behavior.

Although the data is mixed, there is also evidence that an individual's age at earliest memory impacts mental health. Using a clinical population, Parks and Balon (1995) found that individual's with an alleged history of abuse reported early memories that occurred at a later chronological age than their non-abused counterparts, underscoring the theory of repression. In contrast, Spirrison et al. (1997) found that subjects who reported early memories occurring at earlier chronological ages scored significantly higher on measures of maladjustment. Regardless of the different findings, it is important to note that age is a significant EM variable, and can be used to distinguish between groups of pathology.

EM research distinguishing between subgroups of pathology has also been extended to include children and adolescents. Last and Bruhn (1983) found that the second EM obtained from a group of 94 male children could be used to

accurately identify the level of pathology (well adjusted, mildly maladjusted, or severely maladjusted) 59% of the time. In fact, the EM rating system even outperformed a group of experienced clinicians, correctly identifying more subjects according to their level of adjustment. Last and Bruhn (1985) also analyzed the content of childhood EMs to identify the type of pathology. For example, significant group differences were found for schizoid subjects, who made fewer references to their mothers; delinquent subjects, who were overly concerned with their fathers; and hyperactive subjects, who recalled early memories at a later age.

Second, there is some evidence that EMs can be used as a measure of therapeutic change. For example, Chaplin and Orlofsky (1991) re-administered the Early Recollections Survey to the alcoholic sub-population post-treatment. Although none of the early memory indexes reached significance, many variables showed positive changes.

Third, EMs have been used to provide developmental information. Clark (1992) elicited early memories of suicide from 16 undergraduate students. Her results revealed descriptive information about how the concept of suicide develops. For example, Clark was able to identify the average age of the earliest suicidal thought and determine that subjects' earliest exposure to suicide was usually impersonal. Kroger (1990) was able to delineate psychosocial positions

and roles of adolescents using EM themes and Marcia's Ego Identity Status Interview. Moving contentedly alongside a significant other was a theme found in subjects who had obtained identity achievement, while subjects in the diffusion phase produced EMs suggestive of a longing to relate.

Fourth, it is possible that EMs may provide information about health, coping, and normal personality variation. Caruso and Spirrison (1994) designed their study to assess normal range personality traits in a nonclinical sample. The authors found that neuroticism was significantly correlated with destructive cognitive patterns such as superstitious and categorical thinking.

Finally, EM research has begun to demonstrate that it is possible to develop and utilize new projective probes. Fowler et al. (1996) asked subjects to recall an early memory of eating, feeding, or being fed as a symbolic representation of interpersonal dependency needs. This probe was significantly correlated with the Rorschach Oral Dependency (ROD) scale and with therapists' ratings of dependency based on behavioral observations, but was not correlated with measures of aggression or autonomy. The study was significant in that concurrent, predictive, and discriminant validity for a novel probe was demonstrated.

The progress that has been made within the field of early memories, the fact that some are beginning to question the reliability and validity of objective self-report measures (Shedler et al., 1993; Tanaka-Matsumi & Kameoka, 1986), and a

corresponding rise in interest in religious issues (Gorsuch & Miller, 1999; Richards & Bergin, 1997), encouraged efforts aimed at expanding early memory research into the spiritual arena. A rationale for the spiritual assessment in general, and projective spiritual assessment specifically, was presented as a framework, and the currently available projective spiritual measures, including the God/Family Questionnaires, the Nonverbal Measure of God-Concept, and the STARR, were reviewed.

A review of the preliminary research investigating the development of the Early Spiritual Memory Test (ESMT), a spiritual counterpart to the Early Memory Test (EMT), also uncovered several key concepts. First, the ESMT was found to be both reliable and valid, suggesting that it is possible to obtain early spiritual memories (Lin et al., 2000; Lin et al., 2001). Both studies by Lin et al. also found a lack of correlation between the EMT and the ESMT, indicating that the ESMT is measuring something different and new. Finally, the use of clinical judgment to determine an individual's level of health was extended to spiritual matters.

For example, qualitative analysis showed that subjects with low ratings on the EMT and high ratings on the ESMT reported early memories with themes of poor attachment or abandonment, underprotection, instability, negative self-perception, and feelings of fear, sadness, and loneliness (Lin et al., 2001). In contrast, corresponding early spiritual memories contained themes of loving and

reliable relationships with God, improved self-concept, and feelings of assurance, happiness, and emotional stability. Subjects who received high ratings on the EMT and low scores on the ESMT reported a distinct reversal of themes. The data suggested that religion might provide a surrogate attachment for individuals with insecure early attachments in a compensatory manner.

Further research involving early memories and early spiritual memories might focus on the following areas. The literature review clearly revealed a lack of a consistent method for obtaining early memories, a lack of uniform scoring criteria to rate early memories, and a lack of a standardized rating system to interpret early memories. It is important that researchers work to resolve this in order to more effectively organize resulting conclusions. Preliminary conclusions can be drawn from studies investigating early memories and therapeutic change and normal personality variation; however, further research might examine this more thoroughly.

Additionally, while both clinical and nonclinical populations were utilized in early memory research, early spiritual memory research might attempt to employ clinical populations and other faith populations, such as Buddhists and Mormons, in order to extend generalizability and to gather more information about spiritual health. Clearly, there is much yet to be discovered within the field of early memories, and this author excitedly anticipates what is to come, in hopes

that early memory assessment will ultimately be a means of growth and healing for those who are hurting.

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Appendix A

The Comprehensive Early Memories Scoring System

The Comprehensive Early Memories Scoring System

The following items are rated on the CEMSS. Items are grouped according to nine major categories:

1. *Characters* – Mother, Father, Siblings, Other Caretaking Relatives, Non-family Members, Group, Animals, Non-real Persons, Number of Types.
2. *Settings* – Home, School, Hospital, Neighborhood, Other Place, Unclear, Number of Types.
3. *Sensory-Motor Aspect* – Visual, Auditory, Olfactory, Tactile, Gustatory, Motor, Proximal vs. Distal Senses, Number of Types.
4. *Relation to Reality* – Degree to which EM is logically connected and credible story.
5. *Object Relations* – Perception of Others, Perception of Self, Perception of the Environment, Individual Distinctiveness, Degree of Individual Contact.
6. *Thematic Content* – Care Giver, Care Receiver, Deprived of Care, Care Depriver, Mastery, Encouraged, Defiant Autonomy, Mastery Failure, Cooperative, Observing Cooperation, Aggressor, Aggressed Upon, Number of Themes.
7. *Affect* – Judged by the Subject, Judged by the Rater.
8. *Damage Aspect* – Self, Others, Animals, Inanimate Objects.
9. *Memory Age*

Appendix B

The Adelphi Early Memory Index (AEMI)

The Adelphi Early Memory Index (AEMI)

1 = not applicable 3 = somewhat applicable
5 = highly applicable

1. Predominant affect tone is positive (e.g., memories convey happiness, contentment, well-being, excitement, etc.).
2. Predominant affect tone is negative (e.g., memories convey sadness, anger, frustration, fear, hurt, etc.).
3. Others are depicted as benevolent; they are seen as sources of gratification, pleasure, comfort, security, etc.
4. Others are depicted as malevolent; they are seen as sources of frustration, pain, punishment, injury, etc.
5. The memories have predominantly positive outcomes (e.g., subject ultimately succeeds, experiences gratification, etc.).
6. The memories have predominantly negative outcomes (e.g., subject ultimately fails, experiences pain, frustration, etc.).
7. Caregivers are portrayed as abandoning or underprotective.
8. Subject comes across as confident, self-assured.
9. Subject comes across as ignored, deprived, not cared for.

Scoring instructions: Rate each item on a 5-point rating scale (1 = not applicable, 3 = somewhat applicable, 5 = highly applicable). Sum the scores for all items, after reversing scores for Items 2,4,6,7, and 9.

VITA

NAME:

Joy M. Bustrum

EDUCATION:

Rosemead School of Psychology Clinical Psychology	Psy.D.		(Cand.)
Rosemead School of Psychology Clinical Psychology	M.A.		2000
Biola University	B.A.	–	1996

INTERNSHIP:

Patton State Hospital Patton, California	2002	–	2003

PRACTICA:

VA Healthcare System Sepulveda, California Chemical Dependency Rotation Neuropsychology Rotation	2001	–	2002
Harbor-UCLA Medical Center Torrance, California Adult Psychiatry Rotation	2000	–	2001
Biola Counseling Center La Mirada, California Outpatient Rotation	2000	–	2001
Whittier Union School District Santa Fe Springs, California School Practicum	1999	–	2000

EMPLOYMENT:

Olive Crest Treatment Services Santa Ana, California Family Preservation Therapist	2001	–	2002

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Organization/Address: BIOLA UNIVERSITY 13800 Biola Avenue La Mirada, CA 90639	Telephone: 562 903 7361 FAX: NA
	E-Mail Address: jbustrum@juno.com Date: 04.06.2003

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